

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00440

1. PLACE OF DEATH o. COUNTY Calvert		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN lb 2 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert Co., Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Victoria	Middle Coates	Last I-29
4. DATE OF DEATH 1957	Month March	Day 11	Year 1957
S. SEX F.	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 11 1872
8. AGE (In years last birthday) 85 yrs.	9. IF UNDER 1 YEAR Months Days	10. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
			12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Benjameia Kyler		14. MOTHER'S MAIDEN NAME Rosetta Kyler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT Huntingtown Md. Granddaughter Dorothy Wallace
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH Heart failure - Demyelinating arteriosclerosis Auto anemia	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 27, 1958, to Jan 29, 1958, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M., from the causes and on the date stated above. ACTUAL SIGNATURE Dr. Roberto De Villanueva		ADDRESS (Street, city or town, state) 54 Remond DATE SIGNED	
PHYSICIAN'S NAME (Type) Dr. Roberto De Villanueva		22a. BURIAL CREMATION REMOVAL (Specify) Feb. 1, 1958	
22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM Little Reformation Church	22d. LOCATION (City, town, or county) Owings, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Leroy E. Berry Huntington, Md.		24a. REC'D BY REGISTRAR DATE FEB 3 '58	24b. REGISTRAR'S SIGNATURE Albert Beach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 5 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

FEB 3 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00441

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		444 Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Maryland b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Calvert				
Prince Frederick		9 Days		Lusby						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
Calvert Co., Hospital										
3. NAME OF DECEASED (Type or print)	First Merle	Middle	Last Cox	4. DATE OF DEATH	Month Jan.	Day 7	Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1883	9. AGE (In years lost birthday) 74 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Builder		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME George M. Cox		14. MOTHER'S MAIDEN NAME Lydia B. Hammersley		Address						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT 216-16-405X Son - Mike Cox Lusby Md.		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Uremia - INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arterio-sclerosis										
DUE TO (c) - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from alive on		Dec. 1957, to Jan 7, 1958, that I last saw the deceased alive on Jan 7, 1958, and that death occurred at 3:30 P.M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state)	DATE SIGNED 1/7/58	
ACTUAL SIGNATURE Roberto De Villarreal		M.D.								
PHYSICIAN'S NAME (Type) Dr. Roberto De Villarreal										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 10, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Middleham Chapel		22d. LOCATION (City, town, or county) Lusby - Calvert Co - Md		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE A. J. Harkness & Cox - Mutual, Md		ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 10 '58		24b. REGISTRAR'S SIGNATURE De Villarreal				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be stained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU Y. S.

JAN 10 1955

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00442

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 File #G221 1-27-58 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lusby</i>		c. LENGTH OF STAY IN 1b <i>Frosty</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) *Marie Ann Hawkins*
 First *Marie* Middle *Ann* Last *Hawkins* 4. DATE OF DEATH *11/19/58*

5. SEX *F* 6. COLOR OF EYES *Blue* 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH
 WIDOWED DIVORCED *Aug 16 Approx.* 9. AGE (In years
 last birthday) *70* yrs. 10. IF UNDER 1 YEAR
 Months *11* Days *0* Hours *0* Min. *0*

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *Waitress* 10b. KIND OF BUSINESS OR INDUSTRY *None* 11. BIRTHPLACE (State or foreign country) *Md* 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME *Andrew Johnson* 14. MOTHER'S MAIDEN NAME *Ann Johnson*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) *No* 16. SOCIAL SECURITY NO. *None* 17. INFORMANT *May Hawkins, Lusby Md*

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) *Cardiac vascular renal disease* DUE TO
442x
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____
 DUE TO
 (c) _____

INTERVAL BETWEEN
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED?
 YES NO
Was feeling lady at 5 AM and died at 10 AM

20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While at work Not while at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
 Hour a. m. p. m. *19* *Lusby* *Calvert* *Md*

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes Accident , Suicide , Homicide , Undetermined cause .

ACTUAL SIGNATURE *H.W. Ward* M.D. CHIEF MEDICAL EXAMINER
 EXAMINER'S NAME (Type) *H.W. Ward* ASSISTANT MEDICAL EXAMINER
 DEPUTY MEDICAL EXAMINER DATE SIGNED *1/19/58*

22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF *1-23-58* 22c. NAME OF CEMETERY OR CREMATORIAL *St. Johns* 22d. LOCATION (City, town, or county) (State) *Lusby* *Md*

23. FUNERAL DIRECTOR'S SIGNATURE *P.E. Sewell Prince Frederick* ADDRESS *101 Main St* 24a. REC'D BY REGISTRAR DATE JAN 22 '58 24b. REGISTRAR'S SIGNATURE *W. E. Smith*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the registrar prior to burial or removal.

V.S. A15ME(5)
 5M 9/55

THE STATE GOVERNMENT OF DELAWARE
EDUCATIONAL INSTITUTE'S CERTIFICATE OF DEATH

BUREAU V. S.

1953 NOV 22

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00443

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>	c. LENGTH OF STAY IN 1b	d. STREET ADDRESS <i>Huntingtown, Md.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			

3. NAME OF DECEASED (Type or print)	First <i>Benjamin J.</i>	Middle <i>Hawkins</i>	Last <i>Hawkins</i>	4. DATE OF DEATH Month Day Year 1 18 1958
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5. SEX <i>m</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 22</i>	9. AGE (in years last birthday) 5 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13. FATHER'S NAME <i>Benj. Hawkins</i>	14. MOTHER'S MAIDEN NAME <i>Waisey Mackall</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Benj. Hawkins Jr. Huntingtown Md</i>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>929.8</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Child was playing and fell in pond</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>While at work</i>		
20c. TIME OF INJURY Month, Day, Year Hour 3 p.m. 1/15 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>farm</i>	20f. (City or town) (County) (State) <i>Calvert Md</i>

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
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ACTUAL SIGNATURE <i>H.W. Ward</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	DATE SIGNED <i>1/15/58</i>
EXAMINER'S NAME (Type) <i>H.W. Ward</i>		

22a. (BURIAL) CREMATION, REMOVAL (Specify) <i>1-18-58</i>	22b. DATE THEREOF <i>1-18-58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Edwards</i>	22d. LOCATION (City, town, or county) (State) <i>Sunderland Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>P.E. Sewell Prince Frederick Md</i>	ADDRESS <i>ADDRESS</i>	24a. REC'D BY REGISTRAR DATE JAN 22 '58	24b. REGISTRAR'S SIGNATURE <i>Alberich</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
SM 9/55

MISSOURI STATE BOARDMENT OF HEALTH - BATESVILLE, MO
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1000

10-14

DECEASED

DECEASED
TO CEMETERY
BY

BUREAU V. S.

JAN 22 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00444

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

447 Items 11,12 Film G224 1-13-58 et

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
<i>Calvert</i>		a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Some Redlands</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Calvert Nursing Home</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>H. Beach Md</i>	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (First Middle Last)		4. DATE OF DEATH	
<i>George J. Shadley</i>		1 / Month 4 Day 1958 Year	
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>1/30/78</i>	
WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (In years <small>month/day</small>) <i>79 yrs.</i>		10. IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Frederick, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Miller</i>		14. MOTHER'S MAIDEN NAME <i>Mary Weissman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Name, no., or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>W 1 S 649</i>	
17. EMPLOYMENT <i>Address</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <i>Calvert vascular renal disease / Mr 442 X</i>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>DUE TO</i> Conditions, if any, which gave rise to immediate cause (b) <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i></i>	
(c) <i>stating the underlying cause lost.</i>		DUE TO <i></i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>had been to fall Cancer test last seen by and died</i>		19. WAS AUTOPSY PERFORMED? <i>NO</i>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>19</i>		20d. INJURY OCCURRED <i>White Not white</i>	
p. m. <i></i>		of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) <i></i>	
		(County) <i></i>	
		(State) <i></i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H.W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <i>J. O'Conor</i>	
EXAMINER'S NAME (Type) <i></i>		DATE SIGNED <i>1/4/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>1-5-57</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Lee's</i>		22d. LOCATION (City, town, or county) <i>Wash DC</i>	
(State) <i></i>		(State) <i></i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home - Wash DC</i>		ADDRESS <i></i>	
24a. REC'D BY REGISTRAR <i>JAN 8 '58</i>		24b. REGISTRAR'S SIGNATURE <i>R. L. Smith</i>	
VS. A15ME(S) 5M 9/55			

MANUFACTURE STATE DEPARTMENT OF HAWAII - GARDEN
MEDICAL EXAMINE & CERTIFICATE OF DEATH

NAME OF PERSON
DECEASED

NAME OF
DOCTOR

NAME OF
HOSPITAL

AGE
SEX

DATE OF DEATH
TIME OF DEATH

NAME AND ADDRESS OF DOCTOR

BUREAU V. S.

JAN 5 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

448

CERTIFICATE OF DEATH

00445

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Cabret</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prune Frederick</i>		c. LENGTH OF STAY IN 1b <i>6 weeks</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cabret Co. Hospital</i>		e. STREET ADDRESS <i>x St. Leonard</i>	
3. NAME OF DECEASED (Type or print) <i>Lucy</i>		4. DATE OF DEATH <i>Jan 7 1958</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
S. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 21, 1867</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewives</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	10c. BIRTHPLACE (State or foreign country) <i>St. Mary's Co., Md.</i>
11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Spaulding</i>		14. MOTHER'S MAIDEN NAME <i>James Matherly</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>?</i>	
17. INFORMANT <i>Harry Jones - Lushy, Md</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Malnutrition</i>	
450.0 Conditions, if any, which gave rise to immediate cause (o), stating the under-lying cause lost. <i></i>		DUE TO (b) DUE TO (c) <i>Cerebral arteriosclerosis</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July</i> , 19 <i>58</i> , to <i>Jan 7</i> , 19 <i>58</i> that I last saw the deceased alive on <i>Jan 7</i> , 19 <i>58</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Edw. Williamson</i> M.D. PHYSICIAN'S NAME (Type) <i>R. D. VILLARREAL</i> M.D.		ADDRESS (Street, city or town, state) <i>5th Street</i> DATE SIGNED <i>1/7/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan 11, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Our Lady Star of the Sea</i>		22d. LOCATION (City, town, or county) (State) <i>Solomons - Cabret - Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. A. Barkness & Son - Mutual, Md</i>		24a. REC'D BY REGISTRAR <i>Q. A. Barkness</i> DATE JAN 10 '58	
		24b. REGISTRAR'S SIGNATURE <i>Q. A. Barkness</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15 (4)
1SM 9/55

CERTIFICATE OF DEATH

Date of Birth

Cause of Death

Signature

BUREAU V. S.

IAN 10 1953

RECEIVED

O DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PMA-3. Page 5 may be retained for your files.

TO FURNAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the record prior to burial, cremation or return to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
224 1-1-50 ans
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00446

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Melvin</i>				c. STATE <i>Md.</i> b. COUNTY <i>Calvert</i>			
c. LENGTH OF STAY IN 1b <i>Life</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Whitney</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Alan W. Ross</i>		First	Middle	Last	4. DATE OF DEATH	Month	Day
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 11, 1898</i>	9. AGE (in years to nearest birthday) yrs. <i>39</i>	IF UNDER 1 YEAR Months <i>8</i> Days <i>20</i>	IF UNDER 24 HRS. Hours <i>11</i> Min. <i>58</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk of Court</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Public office</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>James T. Ross</i>		14. MOTHER'S MAIDEN NAME <i>Mary Blunt</i>		Address <i>The William Island Creek</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Mo</i>		17. INFORMANT		INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-vascular cerebral disease</i> 442x DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), listing the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Found dead by bed about 8 AM</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Calvert</i> (County) <i>Calvert</i> (State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>H. W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Owing red		DATE SIGNED <i>1/3/58</i>	
EXAMINER'S NAME (Type) <i>H. W. WARD</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Jan. 4, 1958</i>		22b. DATE THEREOF <i>Jan. 4, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Waties Memorial Cemetery</i>		22d. LOCATION (City, town, or county) <i>Island Creek, Md.</i> (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. A. Harkness & Son - Mutual, Md.</i>		ADDRESS <i>Mt. Pleasant, Md.</i>		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE			

RECEIVED

NOV 7 1953

BUREAU K-8

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

450

CERTIFICATE OF DEATH

Reg. Dist. No.

00447

1. PLACE OF DEATH a. COUNTY Calvert		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN lb II Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dunkirk			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert Co., Hospital		d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First George	Middle	Last Sherbert	4. DATE OF DEATH	Month Jan.	Day 14	Year 19 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 Sept. 1884	9. AGE (In years ^{bapt. birthday} yrs.) 75	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Screw man		10b. KIND OF BUSINESS OR INDUSTRY State Job Hardware		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Stocket Sherbert		14. MOTHER'S MAIDEN NAME Ida Wilkerson		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 214-24-3880		17. INFORMANT Son-Thomas Sherbert		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Carcinoma of stomach.	
151X		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		DUE TO (b)		INTERVAL BETWEEN ONSET AND DEATH	
151X		DUE TO (c)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Huntingdon Md.	(County) Huntingdon	(State) Md.	
21. I certify that I attended the deceased from 2 mar , 19 57 , to 13 Jan , 19 58 , that I last saw the deceased alive on 13 Jan , 19 58 , and that death occurred at 4 3/4 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE G. Weems							
PHYSICIAN'S NAME (Type) Dr. George Weems							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-17-58	22c. NAME OF CEMETERY OR CREMATORIUM Smithville	22d. LOCATION (City, town, or county) Dunkirk Md.	(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE M. Hutchins		ADDRESS Curry's Md.	24a. REC'D BY REGISTRAR DATE Jan 18 1958	24b. REGISTRAR'S SIGNATURE DeLoach			

© 2000 MTA - 1748F30 THE MTA 30 17472 CW 3 1000

BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
45 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00448

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edelina</i>		c. LENGTH OF STAY IN 1b <i>Adelina</i>		b. COUNTY <i>Calvert</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Ella</i>		First <i>S</i>	Middle <i>Jessie</i>	Last <i>Johnson</i>	4. DATE OF DEATH <i>1/18/58</i>
5. SEX <i>F</i>		6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/18/1833</i>	9. AGE (In years and birthday) <i>15 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md</i>	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <i>Johnson Brooks</i>		14. MOTHER'S MAIDEN NAME <i>Louise Nelson</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Naomy Young, Adelina</i>		Address <i>Condo Vanilla Divine 290</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>422.1</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Found dead about 12 N in bed</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Not applicable</i>			
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>H.W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>H.W. Ward</i>		DATE SIGNED <i>1/18/58</i>			
22a. BURIAL/CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1-11-58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Carrolls</i>		22d. LOCATION (City, town, or county) <i>Baltimore</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. J. Sewell - Prince Frederick</i>		ADDRESS <i>101 Main St., Prince Frederick, MD</i>	24a. REC'D BY REGISTRAR DATE <i>JAN 14 '58</i>		24b. REGISTRAR'S SIGNATURE <i>O.C. Johnson</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the remains prior to burial, cremation, or removal.

MANUFACTURED BY THE STATE OF HAWAII - EXAMINER'S CERTIFICATE OF DATA

BUREAU V. S.

JAN 14 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00449

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PN3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Calvert		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		a. STATE Md		b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		W Beach		c. LENGTH OF STAY IN lb 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		W Beach, Md			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		1st + Chesapeake				d. STREET ADDRESS		1st + Chesapeake		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	7. Smith	Last	4. DATE OF DEATH	Jan	Month	Day	Year	
5. SEX		m	w	6. COLOR OR RACE	WIDOWED <input checked="" type="checkbox"/>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
							23 Nov 1880	77 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		None		10b. KIND OF BUSINESS OR INDUSTRY		Self employed		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
								Del.		USA	
13. FATHER'S NAME		Unknown		14. MOTHER'S MAIDEN NAME		Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, name or dates of service)		No		16. SOCIAL SECURITY NO.		187-07-3783		17. INFORMANT		Address	
								Daughter		W Beach, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY		Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
				Hour	a. m.	19	While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		J. Weems		EXAMINER'S NAME (Type)		G. T. WEEMS		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)				(State)	
Burial		1-8-58		Wash Nat Cemetery, Belair Rd., Md							
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
W. W. Chambers Co 517 11th St E								JAN 8 '58		Weems	

MISSOURI STATE DEPARTMENT OF HEALTH - DIVISION OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE
HEALTH

BUREAU V. S.

JAN 8 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00450

Reg. Dist. No.

453

1. PLACE OF DEATH a. COUNTY Calvert		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b 16 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Republic		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert Co., Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Jerry	Middle	Last Watkins	4. DATE OF DEATH	Month Jan.	Day 2	Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1883		9. AGE (In years last birthday) 65 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 218-14-10760		17. INFORMANT Sister in Law		Address Nettie Commodore Port Republic Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Arteriovenous occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension c.v.d DUE TO (c)									
INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m. 19		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Jan 2, 1958	(County) 1958	(State) 1958
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ A.M., from the causes and on the date stated above. ACTUAL SIGNATURE Roberto De Villarreal ADDRESS (Street, city or town, state) St. Leonard DATE SIGNED 1/25/58									
PHYSICIAN'S NAME (Type) Dr. Roberto De Villarreal									
22a. BURIAL/CREMATION, REMOVAL (Specify) 1 - 4 - 58	22b. DATE THEREOF 1 - 4 - 58	22c. NAME OF CEMETERY OR CREMATORIUM Browns		22d. LOCATION (City, town, or county) Port Republic, Md.		(State) 1958			
23. FUNERAL DIRECTOR'S SIGNATURE P. E. Sewell		ADDRESS Prince Frederick Md.		24a. REC'D BY REGISTRAR DATE 1/25/58		24b. REGISTRAR'S SIGNATURE John J. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tranit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/SS

CERTIFICATE OF DEATH

MATERIAL

BY DR.

C.

BUREAU V. S.

JAN 7 1968

RECEIVED